FORM MHCA 06

DEPARTMENT OF HEALTH

72-HOUR ASSESSMENT AND FINDINGS OF MEDICAL PRACTITIONER ANDANOTHER MENTAL HEALTH CARE PRACTITIONER AFTER HEAD OF HEALTH ESTABLISHMENT HAS APPROVED INVOLUNTARY CARE, TREATMENT AND REHABILITATION SERVICES
[Section 34(1) of the Act]

Section 1

Surname of User .....
First name(s) of User .....
Date of birth ..... or estimated age .....

Gender: Male☐ Female☐

Occupation ..... Marital status: S☐ M☐ D☐ W☐
Residential address:.....
.....
.....
.....
.....

Section 2

Date and time of the beginning of 72-hour assessment: .....
Place of assessment: .....

Section 3

(a)General physical health**(To be completed by medical practitioners only):**
.....
.....
.....

(b) Are there signs of injuries? Yes☐ No☐
If yes, please indicated whether you believe this is as a result of abuse?

Yes☐ No☐

If yes, was this abuse reported/investigated? Yes☐ No☐Not known☐

(c) Are there signs of communicable diseases? Yes☐ No☐

If the answer to (b) or (c) is Yes, give further particulars:

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……..
…….
……..

Section 4

Past mental health history of the User(State dates and places):

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.....
.....

Section 5

Mental health status of the User during the 72 hours assessment period:

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.....
.....

Section 6

Type of illness (provisional diagnosis):

.....
.....
.....

In my opinion the above-mentioned User─

has homicidal tendencies due to mental illness Yes☐ No☐

has suicidal tendencies due to mental illness Yes☐ No☐

isat risk due to mental illness Yes☐ No☐

Section 7

Recommendation to head of health establishment - application for involuntary care:

Is the User capable of making an informed decision on the need to receive care, treatment

and rehabilitation services?: Yes☐ No☐

Does the User refuse to receive care, treatment and rehabilitation services? Yes☐ No☐

Is the User in your view, likely to inflict serious harm on him /herself or others?

Yes☐ No☐

Is the care, treatment and rehabilitation, in your view necessary for the User's financial interests and reputation? Yes☐ No☐

Section 8
Based on the abovementioned information my recommendation to the head of health establishment is that the User should either:

1. Receive voluntary care, treatment and rehabilitation service☐
or

2. Receive assisted care, treatment and rehabilitation services ☐
or
3. Continue to receive involuntary in-patient care, treatment and rehabilitation services ☐
or

4. Receive involuntary out-patient care, treatment and rehabilitation services ☐
or

5. Be discharged from the Mental Health Care Act☐

Section 9
I declare that I have personally informed the mental health care User of his/her rights, including his/her right to representation including the right to legal representation and/or Legal Aid, and the right to have his/her financial interests and/or reputation safeguarded.
Comment:……
……
……..
……
……..
……..

Section 10
Print initials and surname;..... ……
Registration Category: …….
Signature:…….
Date:…….

Category of designated mental health care practitioner for example 'nurse', psychologist' or 'medical practitioner': .....
Date: .....
Place: .....